		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028134

Facility Name: Lakeview Living Center

Address: 7270 South Shore Drive (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 721-7700 **Fax #** (773) 721-9712

IDPA ID Number: 363234108001

Date of Initial License for Current Owners: 05/23/83

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/1/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	145	Intermediate/DD	145	53,070	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	53,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	46,316	366		46,682	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,316	366		46,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.96%

D. How many bed-hold days during this year were paid by Public Aid? 1,600 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 5/23/83

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/01/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 **Report Period Beginning:** 07/1/99 **Ending:** 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	185,610	17,532	18,043	221,185		221,185		221,185			1
2	Food Purchase		232,045		232,045		232,045	(39,894)	192,151			2
3	Housekeeping	95,740	21,259		116,999		116,999		116,999			3
4	Laundry	44,405	14,875		59,280		59,280		59,280			4
5	Heat and Other Utilities			91,280	91,280		91,280	390	91,670			5
6	Maintenance	91,009		73,611	164,620		164,620	6,587	171,207			6
7	Other (specify):*											7
8	**TOTAL General Services**	416,764	285,711	182,934	885,409		885,409	(32,917)	852,492			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,696,228	28,882	24,240	1,749,350		1,749,350	2,612	1,751,962			10
10a	Therapy			14,992	14,992		14,992		14,992			10a
11	Activities		36,538	16,590	53,128		53,128	8,335	61,463			11
12	Social Services	4,201		8,041	12,242		12,242		12,242			12
13	Nurse Aide Training	69,109	2,284	12,324	83,717		83,717		83,717			13
14	Program Transportation			12,367	12,367		12,367		12,367			14
15	Other (specify):* Routine Dental			10,515	10,515		10,515		10,515			15
16	**TOTAL Health Care and Programs**	1,769,538	67,704	99,069	1,936,311		1,936,311	10,947	1,947,258			16
	C. General Administration											
17	Administrative	116,394		372,047	488,441		488,441	(372,047)	116,394			17
18	Directors Fees							22,736	22,736			18
19	Professional Services			72,450	72,450		72,450	92,558	165,008			19
20	Dues, Fees, Subscriptions & Promotions			12,940	12,940		12,940	3,966	16,906			20
21	Clerical & General Office Expenses	298,136	18,001	33,939	350,076		350,076	41,529	391,605			21
22	Employee Benefits & Payroll Taxes			340,207	340,207		340,207	215,470	555,677			22
23	Inservice Training & Education			1,625	1,625		1,625	7,238	8,863			23
24	Travel and Seminar			3,785	3,785		3,785	16,485	20,270			24
25	Other Admin. Staff Transportation			8,158	8,158		8,158	1,038	9,196			25
26	Insurance-Prop.Liab.Malpractice			2,541	2,541		2,541	37,219	39,760			26
27	Other (specify):*											27
28	**TOTAL General Administration**	414,530	18,001	847,692	1,280,223		1,280,223	66,192	1,346,415			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,600,832	371,416	1,129,695	4,101,943		4,101,943	44,222	4,146,165			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lakeview Living Center #0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			153,573	153,573		153,573	6,707	160,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			232,548	232,548		232,548	29,032	261,580			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							12,557	12,557			34
35	Rent-Equipment & Vehicles			32,167	32,167		32,167	13,647	45,814			35
36	Other (specify):*											36
37	**TOTAL Ownership**			418,288	418,288		418,288	61,943	480,231			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			290	290		290		290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,028	237,028		237,028	79,010	316,038			42
43	Other (specify):* **Nonallowable costs**			1,325,735	1,325,735		1,325,735	(1,325,735)				43
44	**TOTAL Special Cost Centers**			1,563,053	1,563,053		1,563,053	(1,246,725)	316,328			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,600,832	371,416	3,111,036	6,083,284		6,083,284	(1,140,560)	4,942,724			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(1,323,250)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(77)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(18,260)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,792)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(211)	43		18
19	Entertainment				19
20	Contributions	(300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(542)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(662)	43		28
29	Other-Attach Schedule See attached Schedule 5A	(10,013)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,357,107)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	216,547		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 216,547		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,140,560)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakeview Living Center
IDPH #: 0028134
6/30/2000

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Vending income offset	(9,320)	21
Nonallowable travel & seminar	(693)	43
Total	(10,013)	

STATE OF ILLINOIS

Lakeview Living Center

ID# 0028134

Report Period Beginning: 07/1/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Centers, Inc. -	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		
See attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 1,668	$ 1,668	1
2	V	10	Medical supplies		Center for Residential Management, Inc.	**	2,612	2,612	2
3	V	11	Activity programming		Center for Residential Management, Inc.	**	7,692	7,692	3
4	V	17	Management fees	71,642	Center for Residential Management, Inc.	**	71,767	125	4
5	V	18	Board fees		Center for Residential Management, Inc.	**	6,839	6,839	5
6	V	19	Professional fees		Center for Residential Management, Inc.	**	12,177	12,177	6
7	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	1,286	1,286	7
8	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	7,578	7,578	8
9	V	22	Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	65,406	65,406	9
10	V	23	Inservice travel & education		Center for Residential Management, Inc.	**			10
11	V	24	Travel & seminar		Center for Residential Management, Inc.	**	5,719	5,719	11
12	V	25	Vehicle expense		Center for Residential Management, Inc.	**	820	820	12
13	V	26	Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	516	516	13
14	Total			$ 71,642			$ 184,080	$ * 112,438	14

** Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Center for Residential Management, Inc.	**	$ 2,851	$ 2,851	15
16	V	32	Interest expense		Center for Residential Management, Inc.	**	1,861	1,861	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 4,712	$ * 4,712	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Residential Centers, Inc.	100.00%	$ 46,375	$ 46,375	15
16	V	18	Board fees		Residential Centers, Inc.	100.00%	15,897	15,897	16
17	V	19	Professional fees		Residential Centers, Inc.	100.00%	32,993	32,993	17
18	V	20	Licenses, dues & subscriptions		Residential Centers, Inc.	100.00%	104	104	18
19	V	21	Office supplies & telephone		Residential Centers, Inc.	100.00%	1,576	1,576	19
20	V	22	Employee benefits & payroll taxes		Residential Centers, Inc.	100.00%	90,066	90,066	20
21	V	24	Travel & seminar		Residential Centers, Inc.	100.00%	912	912	21
22	V	26	Vehicle, fire & liability insurance		Residential Centers, Inc.	100.00%	33,358	33,358	22
23	V	32	Interest expense		Residential Centers, Inc.	100.00%	26,469	26,469	23
24	V	42	Provider participation fees		Residential Centers, Inc.	100.00%	79,010	79,010	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 326,760	$ * 326,760	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 390	$ 390	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	4,919	4,919	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	643	643	17
18	V	17	Management fees	418,547	Developmental Services of Illinois, Inc.	**		(418,547)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	47,388	47,388	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	1,419	1,419	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	41,695	41,695	21
22	V	22	Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	21,261	21,261	22
23	V	23	Inservice travel & education		Developmental Services of Illinois, Inc.	**	7,238	7,238	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	9,854	9,854	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	218	218	25
26	V	26	Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	3,345	3,345	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	3,856	3,856	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	22,754	22,754	28
29	V	34	Rent		Developmental Services of Illinois, Inc.	**	12,557	12,557	29
30	V	35	Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	13,647	13,647	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 418,547			$ 191,184	$ * (227,363)	39

** Developmental Services of Illinois, Inc. is Residential Centers, Inc.'s management company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Ronald Schroeder	President	Board Member	None	8,266	2 hrs/mtg.		Directors Fees	$ 5,534	L18, C8	1
2	Eugene Humphrey	Vice President	Board Member	None	3,843	2 hrs/mtg.		Directors Fees	4,157	L18, C8	2
3	Edward Childers	Secretary	Board Member	None	9,910	2 hrs/mtg.		Directors Fees	4,090	L18, C8	3
4	Robert Bauer	Treasurer	Board Member	None	8,317	2 hrs/mtg.		Directors Fees	3,683	L18, C8	4
5	Orland Bauer	Director	Board Member	None	7,772	2 hrs/mtg.		Directors Fees	1,028	L18, C8	5
6	Shawn Jeffers	Director	Board Member	None	1,989	2 hrs/mtg.		Directors Fees	1,211	L18, C8	6
7	Darrell Boehne	Director	Board Member	None	9,967	2 hrs/mtg.		Directors Fees	3,033	L18, C8	7
8											8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	$ 22,736		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	206,424	20	$ 6,488	$	53,070	$ 1,668	1
2	10	Medical supplies	Bed days available	206,424	20	10,160		53,070	2,612	2
3	17	Management fees	Bed days available	206,424	20	279,150		53,070	71,767	3
4	18	Board fees	Bed days available	206,424	20	26,600		53,070	6,839	4
5	19	Professional fees	Bed days available	206,424	20	47,365		53,070	12,177	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401		53,070	103	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574		53,070	3,747	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615		53,070	7,100	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941		53,070	2,042	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189		53,070	820	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009		53,070	516	11
12	30	Depreciation	Bed days available	206,424	20	11,103		53,070	2,851	12
13	32	Interest expense	Bed days available	206,424	20	7,240		53,070	1,861	13
14										14
15										15
16										16
17	11	Activity programming	Direct method						7,692	17
18	20	Licenses, dues & subscriptions	Direct method						1,183	18
19	21	Office supplies & telephone	Direct method						3,831	19
20	22	Employee benefits & payroll taxes	Direct method						58,306	20
21	24	Travel & seminar	Direct method						3,677	21
22										22
23										23
24										24
25	TOTALS					$ 443,835	$		$ 188,792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Residential Centers, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	193	4	$ 96,535	$	145	$ 46,375	1
2	18	Board fees	Number of beds	193	4	21,800		145	15,897	2
3	19	Professional fees	Number of beds	193	4	43,931		145	32,993	3
4	20	Licenses, dues & subscriptions	Number of beds	193	4	138		145	104	4
5	21	Office supplies & telephone	Number of beds	193	4	2,100		145	1,576	5
6	24	Travel & seminar	Number of beds	193	4	1,268		145	912	6
7	32	Interest expense	Number of beds	193	4	93,326		145	26,469	7
8	42	Provider participation fees	Number of beds	193	4	101,704		145	79,010	8
9										9
10										10
11	22	Employee benefits & payroll taxes	Direct method						90,066	11
12	26	Vehicle, fire & liability insurance	Direct method						33,358	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 360,802	$		$ 326,760	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	206,424	20	$ 1,518	$	53,070	$ 390	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133		53,070	4,919	2
3	11	Activity programming	Bed days available	206,424	20	2,500		53,070	643	3
4	19	Professional fees	Bed days available	206,424	20	184,323		53,070	47,388	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518		53,070	1,419	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176		53,070	41,695	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697		53,070	21,261	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154		53,070	7,238	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328		53,070	9,854	9
10	25	Vehicle expense	Bed days available	206,424	20	846		53,070	218	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012		53,070	3,345	11
12	30	Depreciation	Bed days available	206,424	20	15,000		53,070	3,856	12
13	32	Interest expense	Bed days available	206,424	20	88,507		53,070	22,754	13
14	34	Rent	Bed days available	206,424	20	48,842		53,070	12,557	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081		53,070	13,647	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 743,635	$		$ 191,184	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL Health Fac. Auth.-Bonds		x	Acquisition of Facilities	Annual Pymt	12/01/92	$ 6,160,000	$ 2,847,000	08/15/16	0.0850	$ 219,185	1
2	Lucent Product Finance		x	Phone System	$522.00	01/13/96	23,095	4,896	04/13/01	0.1418	1,099	2
3	NCS Healthcare, Inc.		x	Software/Hardware	$358.00	10/01/98	14,307	9,005	09/30/03	0.1429	1,043	3
4	Premier Capital Group, Inc.		x	Laundry Equipment	$175.00	10/05/99	6,942	6,245	10/05/04	0.1759	876	4
5												5
	Working Capital											
6	Community Bank of Galesburg		x	Line of Credit	None	06/07/00	333,000	143,000	09/07/00	0.1000	24,780	6
7												7
8												8
9	TOTAL Facility Related				$1,055.00		$ 6,537,344	$ 3,010,146			$ 246,983	9
	B. Non-Facility Related*											
10							Miscellaneous Interest Expense				2,196	10
11							Offset Interest Income & Non-allowable Interest Expense				(20,456)	11
12							Allocated from Parent & Management Company				24,615	12
13							Amortization Expense				8,242	13
14	TOTAL Non-Facility Related						$	$			$ 14,597	14
15	TOTALS (line 9+line14)						$ 6,537,344	$ 3,010,146			$ 261,580	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	N/A	
1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,760 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 6

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	26,080	1988	41,516	1
2					2
3	TOTALS	26,080		$ 41,516	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1988	1910	1,585,984	45,314	35	45,314	$	$ 524,782	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1983	5,047		10			5,285	9
10	Building Improvement			1984	42,110		15			42,518	10
11	Building Improvement			1985	102,043		10			102,043	11
12	Building Improvement			1986	23,799		20			23,799	12
13	Building Improvement			1987	30,173		20			30,173	13
14	Building Improvement			1990	94,921	7,637	15	7,637		71,661	14
15	Building Improvement			1991	700	70	10	70		636	15
16	Building Improvement			1992	9,135	609	15	609		4,441	16
17	Building Improvement			1993	112,022	9,898	15	9,898		66,604	17
18	Building Improvement			1993	115,471	7,698	15	7,698		50,037	18
19	Building Improvement			1994	35,926	5,101	10	5,101		31,072	19
20	Building Improvement			1995	32,918	2,195	15	2,195		11,650	20
21	Phone System			1996	23,095	2,310	10	2,310		10,202	21
22	Install Fire Hose			1995	1,228	82	15	82		375	22
23	Elevator Improvements			1996	3,356	224	15	224		970	23
24	Reception Area			1996	1,598	107	15	107		453	24
25	Two Sets of Steel Doors			1995	3,250	217	15	217		1,011	25
26	Cabinets in Reception Area			1995	3,500	233	15	233		1,069	26
27	Motor for Elevator			1996	2,042	136	15	136		533	27
28	Tub Resurfacing			1996	4,900	327	15	327		1,252	28
29	Concrete Ramp			1996	700	47	15	47		175	29
30	Roof Shaft & Exhaust			1996	1,110	74	15	74		278	30
31	Floor Drain			1997	2,300	153	15	153		511	31
32	Box Elevator			1997	1,950	130	15	130		412	32
33	Concrete Lunch Area			1997	4,313	288	15	288		911	33
34	Roof Work			1997	45,658	3,044	15	3,044		9,639	34
35	Box on Elevator			1998	525	35	15	35		102	35
36	TOTAL (lines 4 thru 35)				$ 2,289,774	$ 85,929		$ 85,929	$	$ 992,594	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4								$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Lighting			1998	2,715	181	15	181		498	9
10	Plumbing			1998	700	47	15	47		117	10
11	Sprinkler System			1998	2,531	169	15	169		473	11
12	Rooftop Exhaust Fan			1998	635	42	15	42		109	12
13	Electric Door Strike			1998	582	39	15	39		75	13
14	Glass			1998	679	45	15	45		128	14
15	Carpet			1999	518	34	15	34		49	15
16	Door			1999	680	30	15	30		30	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 9,040	$ 587		$ 587	$	$ 1,479	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 666,456	$ 61,375	$ 61,375	$	5-10 yrs	$ 590,925	37
38	Current Year Purchases	76,405	3,476	3,476		10 yrs	3,476	38
39	Fully Depreciated Assets							39
40	Parent Company & Management Company Allocation			6,707	6,707			40
41	TOTALS	$ 742,861	$ 64,851	$ 71,558	$ 6,707		$ 594,401	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transportation	1996 Olds Ciera Wagon	1998	11,030	2,206	2,206	$	5	5,515	42
43										43
44										44
45										45
46	TOTALS			$ 11,030	$ 2,206	$ 2,206	$		$ 5,515	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	3,094,221	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	153,573	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	160,280	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	6,707	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,593,989	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Parent and management company allocations			12,557			6
7	TOTAL				$ 12,557 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 30,490 Description: Lawn Mower $150; Dishwasher $2,399; Copier $14,318; Mgmt Company Allocation $13,623
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1992 Ford Van	$ 1,275	$ 15,300	17
18					18
19					19
20	Allocated from management company			24	20
21	TOTAL		$ 1,275	$ 15,324	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 12,324	$	$ 12,324
2	Books and Supplies			2,284		2,284
3	Classroom Wages	(a)		69,109		69,109
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 83,717	$	$ 83,717
10	SUM OF line 9, col. 1 and 2	(e)	$ 83,717			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	79
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	79

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$			$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Eye Care	L39, C3			2	290		2	290	13
14	TOTAL			$	2	$ 290	$	2	$ 290	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 107,103)	998,953	998,953	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,358	6,358	6
7	Other Prepaid Expenses	37,000	37,000	7
8	Accounts Receivable (owners or related parties)	3,504,139	3,504,139	8
9	Other(specify): See Attached Schedule 17A	357,899	357,899	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,904,349	$ 4,904,349	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	41,516	41,516	13
14	Buildings, at Historical Cost	1,585,984	1,585,984	14
15	Leasehold Improvements, at Historical Cost	676,904	712,830	15
16	Equipment, at Historical Cost	789,817	753,891	16
17	Accumulated Depreciation (book methods)	(1,593,989)	(1,593,989)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	540,356	540,356	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Bond Fees	128,455	128,455	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,169,043	$ 2,169,043	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,073,392	$ 7,073,392	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 271,722	$ 271,722	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	143,000	143,000	29
30	Accrued Salaries Payable	73,372	73,372	30
31	Accrued Taxes Payable (excluding real estate taxes)	242	242	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	120,998	120,998	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	558,077	558,077	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,167,411	$ 1,167,411	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,146	20,146	39
40	Mortgage Payable			40
41	Bonds Payable	2,847,000	2,847,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,867,146	$ 2,867,146	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,034,557	$ 4,034,557	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,038,835	$ 3,038,835	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,073,392	$ 7,073,392	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lakeview Living Center
IDPH #: 0028134
6/30/2000

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other Current Assets		
Prepaid Deposit	2,124	2,124
Leasehold Deposit	732	732
Due From Third Party	355,043	355,043
	357,899	357,899
Line 36 - Other Current Liabilities		
Accrued Expense	370,809	370,809
Accrued Legal and Accounting	34,589	34,589
Accrued Participation Fees	79,008	79,008
Accrued Insurance Payable	2,013	2,013
Due To Third Party	71,658	71,658
	558,077	558,077

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,754,067	1
2	Restatements (describe):		2
3	**Prior year audit adjustment**	(53,995)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,700,072	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	724,174	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company & management allocation**	(385,411)	15
16	Other (describe) **(added back in column 7)**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 338,763	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,038,835	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,363,347	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,363,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	1,323,250	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	91,163	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,414,413	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,260	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	9,320	28
28a	Miscellaneous Income	2,118	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,438	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,807,458	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	885,409	31
32	Health Care	1,936,311	32
33	General Administration	1,280,223	33
	B. Capital Expense		
34	Ownership	418,288	34
	C. Ancillary Expense		
35	Special Cost Centers	1,326,025	35
36	Provider Participation Fee	237,028	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,083,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	724,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 724,174	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Residential Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,995	2,085	44,060	$ 21.13	1
2	Assistant Director of Nursing	1,640	1,936	31,012	16.02	2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,926	16,063	231,691	14.42	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	9,666	9,666	69,109	7.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	506	525	4,201	8.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,081	24,513	185,610	7.57	15
16	Dishwashers					16
17	Maintenance Workers	6,953	7,574	91,009	12.02	17
18	Housekeepers	11,977	12,801	95,740	7.48	18
19	Laundry	4,732	5,313	44,405	8.36	19
20	Administrator	2,451	2,591	59,941	23.13	20
21	Assistant Administrator					21
22	Other Administrative	2,355	2,436	56,453	23.17	22
23	Office Manager					23
24	Clerical	17,189	18,406	298,136	16.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	16,582	17,140	220,001	12.84	28
29	Resident Services Coordinator	2,695	2,905	44,792	15.42	29
30	Habilitation Aides (DD Homes)	158,918	168,851	1,124,672	6.66	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,666	292,805	$ 2,600,832 *	$ 8.88	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	404	$ 15,543	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	71	3,891	L10a, C3	40
41	Occupational Therapy Consultant	93	5,101	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	100	6,000	L10a, C3	43
44	Activity Consultant	168	24,243	L11, C8	44
45	Social Service Consultant	272	8,041	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	324	24,076	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,432	$ 87,059		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses				50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Absher	Administrator	0.00%	$ 12,449
John Mirecki	Administrator	0.00%	47,492
Parent Company Allocation	See Schedule 21A		56,453
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,394

B. Administrative - Other

Description	Amount
Center for Residential Management, Inc. - Management Fees	$ 300,405
Developmental Services of Illinois, Inc. - Management Fees	71,642
(Management fees eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 372,047
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 1,718
Mangum, Smietanka & Johnson	Legal	39,763
Amer. Exp. Tax & Bus. Serv.	Accounting	7,806
Altschuler, Melvoin & Glasser LLP	Accounting	23,163
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 72,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,584
Unemployment Compensation Insurance	66,203
FICA Taxes	199,121
Employee Health Insurance	117,160
Employee Meals	39,894
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	175
Employee Morale	28,540
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,677

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	7,339
Health Care Worker Background Check	
(Indicate # of checks performed 166)	1,164
Illinois Health Care Association Dues	5,547
MES & Sam's Club Membership Fees	410
State & Local Fees	536
Miscellaneous Dues & Subscriptions	200
Parent Company Allocation	96
Management Company Allocation	1,214
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,906

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,301
Seminar Expense	4,073
Parent Company Allocation	2,041
Management Company Allocation	9,855
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,270

* Attach copy of IMRF notifications

**See instructions.

Lakeview Living Center
IDPH #: 0028134
6/30/2000

Total (agrees to Schedule V, line 19 column 3)		72,450
Parent company allocation:		
American Express Tax & Business Services	Accounting	694
Altschuler, Melvoin & Glasser LLP	Accounting	4,223
Mangum, Smietanka & Johnson	Legal	7,260
Management company allocation:		
American Express Tax & Business Services	Accounting	7,220
Altschuler, Melvoin & Glasser LLP	Accounting	13,706
ADP	Payroll Processing	23,467
Health Outcomes	Consulting	2,995
Corporate allocation:		
American Express Tax & Business Services	Accounting	5,970
Altschuler, Melvoin & Glasser LLP	Accounting	15,881
Mangum, Smietanka & Johnson	Legal	11,142
Total (agrees to Schedule V, line 19 column 8)		165,008

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3		N/A											
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/1/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $5,547**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **316,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **39,894** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **57%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.